RESULTS OBTAINED IN THE NON-SURGICAL TREATMENT OF TUBERCULOSIS OF THE JOINTS*

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The reasons for and against the surgical treatment of joint tuberculosis have been ably presented and discussed by many good writers on the subject. Perhaps the whole argument on the operative treatment of joint tuberculosis is as well presented in the recent work of Goldthwait, Painter and Osgood,[1] as anywhere in recent literature. As I interpret their attitude on this question, it is that we are and should be drifting away from the tendency to operate in these cases in adults as well as in children, but that in selected cases operation may still be considered to be admissible for a variety of reasons, five of which are set forth as being worthy of consideration in connection with radical surgical treatment. Of the five all are held to be invalid under most circumstances. With the views set forth by Goldthwait, Painter and Osgood in this work it is my pleasure to agree most heartily. Their conclusions are at the same time scientific and sensible. It is my purpose, however, in this paper to carry their teachings somewhat further and to strengthen their conclusions if possible, by a series of observations, somewhat different from theirs, on my own patients.

It has been some years since I began to be impressed with the fact that patients with joint tuberculosis coming under our observation who had previously been operated on were, as a general thing, much more seriously disabled and that the active stage of their disease was much more prolonged than even the advanced cases in which the patients had not previously resorted to surgery.

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* Read in the Section on Orthopedic Surgery of the American Medical Association, at the Sixty-Fourth Annual Session, held at Minneapolis, June, 1913.

1. Goldthwait, J. E.; Painter, C. F., and Osgood, R. B.: Diseases of the Bones and Joints, Boston, 1909.

My intention is to compare, in patients operated on and those not operated on, the periods of active disease process and the amounts of resultant deformity. I have therefore checked up recently a series of fifty patients of this character, of whom I had satisfactory records for the purpose. I have attempted to determine the actual period in each during which the disease may be said to have been active. In many cases this was of necessity a matter of estimate, but I have tried to be fair and liberal both to those operated on and to those not operated on. The results of this study show a wide margin of advantage for the patients not operated on. In fact, although the information used is somewhat difficult to determine for statistical purposes, the patients not operated on have done so much better than those who were operated on that the tendency of the conclusions is inevitable, even if a measure of inaccuracy in the original figures should exist.

I found, for example, that of all patients operated on before coming under our care at the Nebraska Orthopedic Hospital and in my private practice and all patients not operated on, the patients operated on averaged a period of active disease much more than twice as great. It is difficult to arrive at any very satisfactory conclusions regarding the amount of difference in the resulting deformity, but conclusions based on estimates as fair as I am able to make them indicate that the patients operated on suffer an amount of deformity greater than the patients not operated on, which also approximates 50 per cent. This fairly agrees with my conclusion as to the length of active disease, for active disease over twice the period would naturally mean more bone and joint destruction and correspondingly greater deformity.

Operation in adults especially is perhaps most frequently invoked as a time-saving expedient. In the patients studied this proved to be a fallacy, as these patients were disabled much longer than the average of patients conservatively treated. Those who did not recover primarily from the surgical operation still thought their treatment practically over, and went or were allowed to go about with the usual result—mixed infection and continued trouble.

There are three or four principal factors which contribute to the bad results which I charge up to surgical

interference in these cases: (1)operation on patients who have not been properly selected: (2) operation by inexperienced surgeons under unfavorable conditions, and (3) failure on the part of experienced surgeons who have done good operations to keep the patient under supervision for proper dressings and after-care until recovery is complete. None of these factors except the patient himself is beyond the control of the surgeon, and it is to be borne in mind that the patient who in the early stages of his disease is intolerant of apparatus will also be impatient in the matter of after-care and should be handled accordingly.

All of our experience with bone and joint tuberculosis teaches us that a large percentage of good results may be obtained by conservative treatment when the diagnosis is made early and the treatment carefully carried out. It is hardly necessary to emphasize here the importance and ease of early diagnosis of joint tuberculosis and the simplicity of early treatment. It is unquestionable that careless diagnosis and ignorance on the part of some overenthusiastic surgeons of the splendid results obtainable by efficient mechanical treatment prompt them to do operations of this kind which might better have been left undone. My own experience has been that equally good results may be obtained even in those patients requiring a minor surgical procedure, even in late cases, when it is combined with careful mechanical treatment and strict surgical after-care.

Some of the literature for the last few years urging radical surgery has done much harm because it has persuaded surgeons to undertake these operations who have neither proper facilities nor suitable surroundings in which to do the kind of surgery these patients then require. It is also true that many good general surgeons, having failed to obtain primary results following these operations, have allowed their patients to drift into less competent hands or even to do their own surgical dressings with the necessarily following mixed infection and chronic sinus.

Patients may recover from a large amount of joint damage under non-surgical treatment. The conclusions from my entire list of patients sufficiently emphasize the point that disability and deformity are much less in the patients not operated on.

In passing it may be well to mention that in this particular series there has been no death in any case in which the patient was not operated on, or in any case in which the patient had the first operation under our care, while there have been three deaths in patients previously operated on.

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